Extended vacancies in the State Planner and other positions at the BBH, combined with recent increases in the complexity and centralization of the DHHS contracting process, including RFP review, caused the FEP RFP release to have been delayed beyond September 1, 2015. Consequently, without an extension of the FFY2014 funds, they will remain unexpended. This is more than unfortunate; the SMHA as alerted SAMHSA and requested an extension of these funds.

On a positive note, the SMHA is currently in the process of finalizing the contract for FEP-EBP training that will utilize the 5% MHBG set-aside funds for FFY2015 and 10% for FFY2016 and FFY2017.

The FFY2014 funds were to have been applied to planning, training, and/or infrastructure development, including execution of a training plan for Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care (CSC). Program implementation efforts were to have been second year plan targets. This remains the plan as defined by the draft contract for First-Episode Psychosis (FEP).

We cannot attach the contract, as it hasn't been completely executed. We will reference the contract language to describe the practice, planned activities, budget, and data collection methods for 2015, 2016, and 2017 dollars. We'll conclude with a description of our intentions to address any foreseen challenges.

Data accumulated over the past two decades supports the value of early intervention following the first episode of psychosis. Clinical research conducted world-wide supports a variety of interventions for ameliorating psychotic symptoms and promoting functional recovery in FEP.

Results from the NIMH funded *Recovery After an Initial Schizophrenia Episode* (RAISE) research initiative suggest that mental health providers across multiple disciplines can learn the principles of CSC for FEP, and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a team-based, collaborative, recovery-oriented approach involving individuals experiencing first episode psychosis, treatment team members, and when appropriate, family members as active participants. CSC components emphasize outreach, low-dosage medications, cognitive and behavioral skills training, supported employment and supported education, case management, and family psychoeducation. While these individual approaches are available to some extent within the current Community Mental Health system, the goal of RAISE is to provide an integrated system of intervention, incorporating varied approaches in a systematic way, tailored to individuals, and achievable in the real-world environments in which people with schizophrenia obtain assistance. CSC also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with such individuals and their family members over time. Peer supports can also be an enhancement in this model.

According to the US Census numbers for 2013, the population of NH is 1,323,459. An estimated 1-2% of the population will experience psychosis, typically between the ages of 15-25. NH has 23 undergraduate colleges and universities with out-of-state enrollment, which has a potential to inflate the numbers of youth experiencing psychosis in the state. Additionally, other populations to be included are veterans and refugees. NH has become home to over 7500 refugees in recent years and special care must be taken to provide for their behavioral health needs, including FEP.

NH plans to use a NAVIGATE training team to train Community Mental Health Centers to establish CSC teams that will continue and expand beyond the training period, using a staged approach. NH will, especially because of the low level of funding provided by the 2015 5% set-aside, start by training 1 – 2

Community Mental Health Centers located in large population centers, and continue with implementation of two to four teams to high clinical fidelity, using lessons learned the first year.

Description of the FEP NAVIGATE Model and Planned Activities

NAVIGATE is an evidence-based practice employing a team-based approach, with all team members trained in fundamental information about FEP and how to use joint decision-making with clients and families. In addition all team members receive training for their specific role that includes motivational interviewing strategies, cognitive-behavioral strategies, and strategies for involving family members and other supporters.

The team from a mental health center will be composed of the following staff members: Program Director, Family Education (FE) Clinician, Prescriber, Individual Resiliency Trainer (IRT), and Supported Employment and Education (SEE) Specialist. Case Management and Peer Support services will also be included in the model.

The vendor will work with the SMHA to develop a training plan in congruence with the NH budget cycle and will implement modified teams at smaller centers that utilize telemedicine with established teams, given that smaller centers may have very few first episode psychosis clients.

Training Plan

In-person training occurs over one year, to be paid through the 5% 2015 set-aside and half of the 10% 2016 10% set-aside to be expended during SFY2016. By the end of the one-year in-person training and the first six months of one year of regular phone consultation, to be paid through the balance of FFY 2016 10% set-aside during SFY2016, staff members will obtain role-specific clinical and support skills.

The NAVIGATE model is manualized, and includes an emphasis on sustainability, and encourages agencies to develop in-house leaders to continue the practice after the training and consultation period has ended. Therefore, the model requires that the Program Director be a licensed clinician who can provide weekly supervision to the members of the team without professional credentials.

Certification and Re-Certification Requirements

There are two types of certification for NAVIGATE: clinical certification and trainer certification. Clinical certification involves the assessment of the use of clinical skills in each component of NAVIGATE, and in the functioning of the team as a whole. After receiving clinical certification, team members may seek trainer certification. Training is provided and clinical certification pursued in the first and second year, using FFY2015 and FFY2016 funds.

Team Fidelity

To become a certified clinical provider of NAVIGATE, teams must provide fully integrated NAVIGATE services to a minimum of 5 clients for a period of 9-12 months in the context of a fully staffed and well-functioning NAVIGATE team. This is assessed by consultation calls with the director, observations of team meetings, and review of records.

Re-certification of clinical fidelity requires a combination of learning about new developments in the field and submitting examples of current clinical work.

Budget

The consultant will also provide access to and ownership of client level demographic and outcomes data generated by enrollment. It is anticipated that the 2015 5% set-aside will be sufficient to cover these costs.

Given the delay in FEP implementation described in the opening paragraphs, we're cautiously budgeting for the increased funds for FFY2016 and FFY2017 based a one-year extension for each year. In other words, we plan to expend FFY2015 funds by September 30, 2016, and FFY2016 funds by September 30, 2017, etc.

Data Collection

The vendor will provide summaries of activity by each FEP team: number of clients referred; number of clients who meet criteria; number of clients enrolled, number of clients who are working and/or in school; number of re-hospitalizations. The vendor will also provide access to and ownership of client level demographic and outcomes data generated by enrollment.

The SMHA's Phoenix system will allow us to track FEP-tagged clients and their service history, along with all of the related data fields submitted via the Universal Reporting System (URS) tables. The online CANS/ANSA system will also capture client baseline and outcomes data. The SMHA is planning to assume costs for this data management system and its eventual integration.

Contingency Planning

Challenges include finding Community Mental Health Centers that are motivated to do the sustained training and implementation work, training the teams in the required skills to a level where they meet criteria for clinical certification, and then bringing teams to a level where its members can be certified as trainers.

The vendor's Training Teams have encountered these same challenges across the country and have developed the training materials and processes, including fidelity measurements, to address them.